Integrated System News Bulletin

Late Medi-Cal Claim Edits

Attention: All Providers

STOP – Impact on You

Effective August 27, 2009, two new business edits will be implemented in the Integrated System to validate late Medi-Cal claims, submitted via Direct Data Entry (DDE) or Electronic Data Interchange (EDI) as follows:

1. Medi-Cal claims submitted with a date of service (DOS) where the month of service is greater than six (6) months from the submit date will require a valid late code.

2. Medi-Cal claims submitted with a DOS where the month of service is greater than twelve (12) months from the submit date will need to be billed manually.

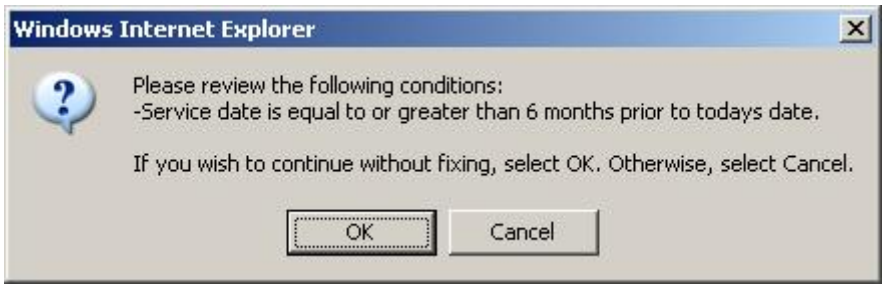
CAUTION – What You Need to Know

Local Plan DDE Providers

The IS will validate all Medi-Cal billable claims with a DOS where the month of service is greater than 6 months from the submit date and do not contain a valid late code. The IS will stop the claim from being submitted and will prompt you with the following denial message when you click the '**Submit**' button on the '**Claim**' screen:

The IS will validate all Medi-Cal billable claims with a DOS where the month of service is greater than 12 months from the submit date regardless of a valid late code. The IS will stop the claim from being submitted and will prompt you with the following denial message when you click the '**Submit**' button on the '**Claim**' screen:

An existing edit still validates all other claims where the DOS is equal to or greater than 6 months from the submit date. This existing edit is only a warning. You may click '**OK**' to continue or click '**Cancel**' to stop. The following message will still display when you click the '**Submit**' button on the '**Claim**' screen:



Local Plan EDI Providers

Late Medi-Cal claims submitted with a DOS where the month of service is greater than 12 months from the submit date will be denied with Rule 28 for 837 Professional and Rule 21 for 837 Institutional claims **(Ensure the Service Date is not more than a year before the current date)**. A negative 835 will be returned.

Late Medi-Cal claims submitted with a DOS where the month of service is greater than 6 months from the submit date and without a valid late code will be denied with the Rule 86 for 837 Professional and Rule 56 for 837 Institutional claims **(Validate Medi-Cal Billable Late Claims)**. A negative 835 will be returned.

Fee-For-Service (FFS) EDI & DDE Providers

Late FFS 837 Professional Medi-Cal claims submitted with a DOS where the month of service is greater than 12 months from the submit date and with a valid late code will also be denied with Rule 28. However, if claims do not contain a valid late code and the month of service is greater than 6 months from the submit date, these EDI claims will be denied with the existing Rule 19 **(Validate Late Claims)**. A negative 835 will be returned. DDE claims will be prompted with the following denial message:

GO – What You Need to Do

To avoid encountering these denial messages or rule denials, it is recommended that providers submit their claims in a timely manner.

If you have any questions regarding these new edits in the IS, please contact the Help Desk at (213) 351-1335. If you have FFS billing questions, please contact the Provider Relations Unit at (213) 738-3311. If you have manual billing questions, please contact the Revenue Management Division via phone at (213) 480-3444 or via email at revenuemanagement@dmh.lacounty.gov.